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Securing funds for health promotion: lessons from health promotion foundations based on experiences from Austria, Australia, Germany, Hungary and Switzerland

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SUMMARY

Worldwide, countries face the challenge of securing funds for health promotion. To address this issue, some governments have established health promotion foundations, which are statutory bodies with long-term and recurrent public resources. This article draws on experiences from Austria, Australia, Germany, Hungary and Switzerland to illustrate four lessons learned from the foundation model to secure funding for health promotion. These lessons are concerned with: (i) the broad spectrum of potential revenue sources for health promotion foundations within national contexts; (ii) legislative anchoring of foundation revenues as a base for financial sustainability; (iii) co-financing as a means to increase funds and shared commitment for health promotion; (iv) complementarity of foundations to existing

funding. Synthesizing the lessons, we discuss health promotion foundations in relation to wider concerns for investment in health based on the values of sustainability, solidarity and stewardship. We recommend policy-makers and researchers take notice of health promotion foundations as an alternative model for securing funds for health promotion, and appreciate their potential for integrating inter-sectoral revenue collection and inter-sectoral funding strategies. However, health promotion foundations are not a magic bullet. They also pose challenges to coordination and public sector stewardship. Therefore, health promotion foundations will need to act in concert with other governance instruments as part of a wider societal agenda for investment in health.

Key words: financing; funding; health promotion foundation; investment

INTRODUCTION

OECD countries allocate over 90% of public expenditure on health to healthcare. Investment in health promotion and disease prevention amounts, on average, to 3.1% of public

expenditure on health: ranging between 0.7% in Iceland and 6.6% in Canada (OECD, 2007; data from 2005). More than two decades after the Ottawa Charter and its call to reorient health services towards health promotion (WHO, 1986), financial commitment to health

promotion remains small compared with curative services. While cross-country comparisons of levels of health promotion spending seem intricate due to conceptual and methodological variations (Weinbrenner *et al.*, 2007), there is wide agreement that investment in health promotion remains inadequate in view of rising health inequalities and the growing prevalence of chronic conditions such as obesity, hypertension and diabetes [e.g. (Bennett, 2003; Bayarsaikhan and Muiser, 2007; Wise and Nutbeam, 2007; WHO, 2009a; Ziglio *et al.*, 2000a)].

Worldwide, progress has been rather slow when it comes to realizing and sustaining financing arrangements for health promotion (WHO, 2005). How to secure funds for health promotion on a long-term basis, beyond short-term political timeframes, is a growing concern in many low-, middle- and high-income countries. Government spending on population-wide health promotion services tend to be *ad hoc* and issue-based (Bennett, 2003; Bayarsaikhan and Muiser, 2007). Conventional funding by government agencies is also vulnerable to annual budget revisions and to changing priorities in response to electoral cycles. To achieve sustained investment in health promotion, there is a need to explore alternative models of securing funds for health promotion (Tangcharoensathien *et al.*, 2009).

Health promotion foundations may be such a model. Health promotion foundations are statutory bodies endowed with long-term and recurrent public resources for promoting health (Carroll, 2004; Mouy and Barr, 2006). The Nairobi Call to Action, adopted in 2009 by the participants of the 7th Global Conference on Health Promotion, promoted this model by urging countries to 'secure adequate financing by establishing stable and sustainable financing at all levels, for example health promotion foundations' (WHO, 2009b, p. 4).

Health promotion foundations have been described as an Australian invention intended to tackle the public health problems of tobacco sponsorship (Holman *et al.*, 1996). In the 1980s and early 1990s, four Australian states established health promotion foundations to manage a dedicated levy on tobacco taxes. Health promotion foundations were used to invest those funds in tobacco sponsorship replacement and other health promotion activities (Carroll, 2004). Foundations continue in two Australian

states, Victoria (VicHealth) and Western Australia (Healthway). Since then, several countries and states have established health promotion foundations, such as Austria, Switzerland, Thailand, Singapore, Korea, Malaysia, Mongolia and Tonga. Funding approaches have diversified over time and between countries. The growing experiences from health promotion foundations in securing funds for health promotion may be useful for various countries looking for their own models of financing health promotion.

The aim of our study was to investigate how and why health promotion foundations can secure funding for health promotion. Here we draw on experiences from three foundations in high-income countries—the Victorian Health Promotion Foundation (VicHealth), the Austrian Health Promotion Foundation and Health Promotion Switzerland—to illustrate four lessons learned from the foundation model. We also integrate experiences from Germany and Hungary, where efforts have failed to secure long-term funding within a health promotion foundation. Subsequently, we synthesize these lessons in relation to wider concerns for investment for health. We conclude with implications for research and policy.

METHODS

Data for this article were collected between February and August 2010. We followed a case study method which is 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident' (Yin, 1994, p. 13). The approach is therefore well-suited to explore the diverse and presumably context-dependent (Carroll, 2004) financing of health promotion foundations. Data were triangulated as we integrated multiple sources of evidence including scientific and grey literature obtained through PubMed, Web of Science, EconLit, Google and Google Scholar; annual reports of the foundations; and eight expert telephone interviews. A set of questions was developed to guide data collection.

We used purposive sampling to identify experts from within and from outside the foundations whose profound insight could help to deepen understanding of the case (Gray, 2009).

Table 1: Legislative funding sources of health promotion foundations

VicHealth (1987–97)	VicHealth (since 1997)	Health Promotion Switzerland	Austrian Health Promotion Foundation
Dedicated levy of 5% on top of existing state tobacco fees	Appropriation of Victoria's annual health budget	Levy of 2.4 CHF (€1.6) on top of compulsory health insurance premiums	Dedicated sum of €7.25 million from sales-tax revenue

VicHealth (2006), GFCH (2009), Hofmarcher and Rack (2006).

Interviewees for each existing foundation included one high-ranking foundation staff member (two Chief Executives and one Head of Knowledge Management) and one external expert (two professors knowledgeable on the topic and one Head of Section in a Health Ministry). Interviews with a professor from Hungary and a German Sickness Fund representative served to integrate the experiences from these countries. We assured anonymity to the interviewees and gave them the opportunity to comment on the results to enhance trustworthiness of conclusions.

The interviews were semi-structured; based on a similar interview guide but conducted in a flexible manner so as to capture novel themes (Gray, 2009). Data collection and analysis were informed by the notion of multiple layers of context (Hinds *et al.*, 1992). The presumed embeddedness of a case into direct legislative, economic and political contexts and meta contexts which embrace societal values, served as a conceptual device for perusing the transcribed interviews and documents collected. We used thematic analysis (Silverman, 2001) to identify themes or patterns by contrasting and comparing different data sources and linking them back to the theoretical framework. Here we present and discuss four lessons that emerged from thematic analysis.

RESULTS; LESSONS LEARNED FROM HEALTH PROMOTION FOUNDATIONS

A broad spectrum of potential sources to finance health promotion

Securing funding for health promotion starts with finding a suitable funding source. Health promotion foundations draw on a broad range of funding sources, which are not necessarily limited to the health sector (e.g. social insurance contributions, health budget appropriations),

but can also originate from beyond the health sector (e.g. dedicated tobacco taxes, sales-tax appropriations, Table 1). However, country experiences indicate that political and legislative contexts may influence both choice and feasibility of specific funding sources.

In *Tobacco Act 1987*, the Victorian *Tobacco Act* stipulated a tobacco tax increase from 25 to 30% of the wholesale price, and earmarked the revenues of the 5% tax increase to a new health promotion foundation: VicHealth. This arrangement served two purposes. First, raised prices were intended to discourage tobacco consumption financially. Second, tobacco tax revenues were intended to be dedicated to health promotion. The political context for this model was favourable, as opinion polls showed high public support for tobacco tax increases, even among smokers, if these funds were invested into health promotion. Funding health promotion through a dedicated 'sin' tax was a worldwide first and raised attention nationally and internationally (VicHealth, 2005).

In 1997, however, the High Court of Australia invalidated state government tobacco taxes, because constitutionally states may levy taxes only for specific purposes. Ironically, the earmarked levy for VicHealth might have been the only constitutional element, but this was never examined by the Court (Borland *et al.*, 2009). The state Health Department agreed to resume financing VicHealth out of its budget. Thereby, the separate health promotion financing stream merged with general health system financing. Since 1998, funding for VicHealth has been determined by the treasurer, as part of Victoria's annual health budget (VicHealth, 2005).

Also in 1998, the Austrian Health Promotion Foundation was like VicHealth entrusted with treasury appropriations as the funding source. In contrast to VicHealth, these appropriations are legislatively fixed and do not affect the health budget. The *Health Promotion Act*

requires the Finance Ministry to deduct an earmarked, annual amount of €7.25 million from sales-tax revenue, before this revenue is distributed among national and regional levels of government (Hofmarcher and Rack, 2006). It seems that this choice was a political statement to emphasize a whole-of-society approach to health promotion financing.

The financing source had been discussed for a long time. Eventually the tax-financed model was a political decision, because the entire health system should be involved, not only the social security system. This was a big step. It was also a time when ideas like the Ottawa Charter became more wide-spread. (Expert 3, 11 March 2010)

In Switzerland, the *Sickness Insurance Act* (KVG, 1994) stipulates that Swiss health insurers collect an annual surcharge of CHF2.4 (€1.6) from every insuror on behalf of Health Promotion Switzerland. In contrast to the more fundamental political choices in Austria and Victoria, this financing source may have been more path-dependent.

The choice of health insurance levies was probably an ad-hoc-decision. This financing source was proposed during larger revisions of the Sickness Insurance Act, in analogy to the Swiss Accident Prevention Foundation which is financed through accident insurance. (Expert 5, 17 March 2010)

With initial support from WHO grants, a former staff member of the Hungarian Health Promotion Institute established the Health21 Hungarian foundation as a non-governmental organization in 2003. Three options and attempts to secure long-term financing, however, failed.

One idea was citizen engagement. Hungarian law enables taxpayers to assign 1% of their personal income tax to a foundation they indicate on their tax declaration. But Health21 did not mobilize enough supporters, because few tax-payers use their right, and foundations engaged in culture, animal protection and other fields are competing.

Insurance surcharges and a dedicated tax were unfeasible, too, mainly for economic reasons. (Expert 8, 4 March 2010)

Economic downturn faced by Hungary since 2004 resulted in budgetary restrictions of both the Finance Ministry and the Hungarian National Insurance Fund, which suffers from low insurance contributions and rising health-care costs (Makara and Nemeth, 2009). In this

context, investment in health promotion as 'extra services' might have been considered politically delicate. Even though contextual factors may not always impede efforts to secure funding at all, they can limit the spectrum of available funding sources. In Victoria, for instance, the junction between health promotion funding and health system financing became necessary for legal-constitutional reasons. Nevertheless, within context-specific limits, the country examples presented here reveal various potential sources to finance health promotion.

Co-financing to increase funds and shared commitment for health promotion

In quantitative terms, the funds allocated to health promotion foundations are but a drop in the ocean compared with total health expenditure in the respective countries. However, country experience suggests that co-financing can serve as a means to increase funds and shared commitment for health promotion (Table 2).

While projects funded by VicHealth usually receive funding from other sources but co-financing is not an explicit principle (Expert 1, 15 March 2010), the Austrian Health Promotion Foundation and Health Promotion Switzerland normally fund one- to two-thirds of acknowledged project costs. In 2008, total project costs in Switzerland amounted to €19.6 million. Health Promotion Switzerland contributed, on average, 38.6%. The Austrian Health Promotion Foundation invested €4.24 million into projects; only 17% of the total project costs. The remaining 83% were assumed by providers or external partners such as government or the insurance sector. Thereby, €20.16 million was mobilized for health promotion projects.

Historical evidence for the Austrian Health Promotion Foundation suggests that the co-financing principle may have increased health promotion expenditure of other sectors: while the available budget of the Foundation remained stable, the amount of total co-financed project costs rose from €9 million in 1996 to €14 million in 2001 (Kirschner *et al.*, 2006) to €20.16 million in 2008 (FGÖ, 2009a):

Thanks to the increasing reputation and high quality standards of the Foundation, a grant from the Foundation often serves as door-opener to other funds. One could argue that funds allocated to the

Table 2: Impact of co-financing on available funds for health promotion

	VicHealth	Health Promotion Switzerland	Austrian Health Promotion Foundation
Total health expenditure in 2008 ^a	€16.7 billion (2007/08)	€34.9 billion	€29.5 billion
Statutory revenue in 2008 ^b	€21.3 million ^c	€12.3 million ^d	€7.25 million
Budget per permanent resident in 2008 ^e	€3.9	€1.6	€0.9
Estimated impact of co-financing on available funds for health promotion ^f	€21.3 million (plus x)	€24.94 million Total project costs €19.6 million (including €7.56 million contributed by the foundation) Remaining funds of the foundation: €5.34 million ^g	€23.41 million Total project costs: €20.16 million (including €4.24 million contributed by the foundation) Remaining funds of the foundation: €3.25 million ^h
Budget per permanent resident in 2008 including the impact of co-financing	€3.9 (plus x)	€3.2	€2.8

^aAustrian Institute for Health and Welfare (n.d.), Swiss Federal Council (2009), Austrian Institute of Statistics (2010).

^bBased on VicHealth (2009b), GFCH (2009). All exchange rates from 31 July 2010.

^cBased on AUD 30.8 million appropriated by Government; total income including investment was AUD 32.7 million/€22.7 million (cf. VicHealth, 2009b).

^dBased on CHF 16.73 million from insurée surcharges; total income including interest/investment and not exhausted project grants was CHF 17.39 million/€12.8 million (cf. GFCH, 2009).

^eAuthors' calculations based on: 5.43 million permanent residents in Victoria (www.census.abs.gov), 7.7 million in Switzerland (www.bfs.admin.ch), 8.3 million in Austria (www.statistik.at).

^fPersonal estimations based on GFCH (2009), FGÖ (2009a).

^gThese are allocated to research, conferences, services, campaigns and administrative expenditure.

^hIbid.

Foundation reflect rather symbolic commitment, but co-financing arrangements make them quite considerable. (Expert 2, 11 March 2010)

Although co-financing would always entail opportunity costs, it appears that health promotion foundations can, even with their own rather small revenues, multiply available funds for health promotion through inter-sectoral co-financing action. Nevertheless, since 2009, the Austrian Health Promotion Foundation offers full financing to small- and medium-sized companies. As these members of the industrial sector are seen as particular victims of the economic crisis, full financing shall encourage health promotion projects despite economic constraints (FGÖ, 2009b). Thus, co-financing may increase funds and shared commitment for health promotion, but its appropriateness apparently depends also on the type of grant receiver and the economic climate.

Legislative anchoring of foundation revenues as a base for financial sustainability

The health promotion foundations studied receive dedicated public resources. This has enhanced the financial sustainability of

foundation budgets and enables ongoing funding commitment. But despite legislative anchoring, volatilities in revenues can be observed.

Until 1997, the budget for VicHealth could, in theory, fluctuate depending on the amount of tobacco tax revenue. VicHealth was initially funded from a 5% hypothecation of tobacco taxes, meaning that increased tax revenue would increase funds for VicHealth. As tobacco tax revenue has indeed been constantly rising between 1989 and 1992 (VicHealth, 2006), despite a price-responsive decrease in consumption of dutied tobacco products (Scollo and Lal, 2007) and due to rising tobacco tax rates (Scollo, 2008), it remains unclear why VicHealth's budget decreased during that time. In 1992, following a fiscal crisis, funds for VicHealth were capped without inflation adjustment at €17 million. Thus, hypothecation became nominal only. Between 1993 and 1996, funds were capped again at €15 million. In 1996/97, an indexation of 3% was introduced in order to adjust for inflation (VicHealth, 2006), which slightly exceeds the average inflation rate of about 2.8% between 1996 and 2008 (authors' calculations based on CPI, 2010). In 2007/08, VicHealth's

budget again reached the level of 1989/90 (VicHealth, 2009a). Nevertheless, given annual depreciation, VicHealth's budget remained stable after the capping of the appropriations.

Health Promotion Switzerland's budget depends on the number of insurees, i.e. resident population size. Corresponding to increasing population growth (from 0.2% in 1997 to 1.4% in 2008, mainly due to foreign nationals assuming residence in Switzerland; BAS, 2010), the revenue base for Health Promotion Switzerland has been constantly rising. However, the levy per insuree was never inflation-adjusted. Given an average annual inflation rate of 1% between 1996 and 2008 (personal calculations based on IndexMundi, 2010), the budget increased in absolute terms, but decreased relative to the purchasing power by 12%.

In contrast to the other foundations, the Austrian Health Promotion Foundation has a legislatively determined budget of €7.25 million. Due to an average inflation rate of 2%, however, this amount has depreciated by 20% between 1998 and 2008 (authors' calculations based on WKO, 2010). Demanding a budget increase has been delicate in Austria, partly because available funds were not utilized (Kirschner *et al.*, 2006). Paradoxically, it seems that the reason was not a lack of need but a lack of capacity:

The first public health-education programmes in Austria started end of the 1990s, so initially few professionals were qualified to apply for project funding. But by now legislative anchoring of funds has probably helped to sustain continuous funding. (Expert 4, 11 March 2010)

Thus, country experiences suggest that legislative ring-fencing tends to improve financial sustainability, but can be challenged by factors such as lack of professional capacity, fiscal crises or gradual depreciation of funds.

Complementarity of foundations to existing funding

Considering the overall societal investment in health promotion, the key issue is whether health promotion foundations will in concert with other financing tools increase available funds for health promotion, or whether these remain at the same level. As experience from Germany and Victoria illustrates, the establishment of a new funding agency does not necessarily add new funds on top of existing resources.

In Germany, the Ministry of Health failed twice, in 2005 and 2007, to establish a health promotion foundation intended to be jointly financed by sickness funds, accident, pension and long-term care insurance (BMG, 2007). Critics, however, pointed to the lack of involvement of unemployment insurance—refused by the Employment Ministry—and of private insurers, although these sectors were seen as profiting from health promotion measures. While the reasons for failure of a German health promotion foundation also related to legal–constitutional obstacles, the political–ethical debate centred on using a health promotion foundation to relieve government-funded public health services at the expense of social security (Hajen, 2006; SpiK, 2007; Wanek, 2008). Concerns had been raised that a health promotion foundation would merely reshuffle funds.

Insurers welcomed the tentative inter-sectoral arrangement, but a key issue was the possible shifting of tasks from underfinanced public health services to social security. (Expert 7, 17 March 2010)

VicHealth indeed assumed financing for some previously government-funded programmes, such as the tobacco control programme 'Quit' (Borland *et al.*, 2009). Due to cost- and task-shifting from government, VicHealth replaced rather than complemented existing funding. Arguably, VicHealth's funding source, the state health budget, weakens the negotiation position of the foundation in this respect. The Austrian Health Promotion Foundation and Health Promotion Switzerland, however, are legally protected against cost- and task-shifting. They are not mandated to fund obligatory government or social insurance tasks (GFCH, 2002; FGÖ, 2009c).

Moreover, all foundations studied seem to achieve distinctiveness through a mix of inter-sectoral funding strategies. This mix ranges across funding practice projects, research, evaluation, networking, workforce development and capacity-building in cooperation with sectors such as local and/or regional government, private sector enterprises, education and research institutions, non-governmental and community organizations (GFCH, 2002; FGÖ, 2009a; VicHealth, 2009a). Thus, it seems that health promotion foundations can, based on legislative provisions and their own initiative, indeed complement existing forms of health promotion funding by government and social insurance.

DISCUSSION

The lessons presented in this article suggest that health promotion foundations can mobilize complementary funding for health promotion on a long-term basis. However, their financial sustainability can also be challenged and their financial contribution remains relatively small. Building on the notion of multiple layers of context (Hinds *et al.*, 1992), we relate these lessons to a possible meta-context of securing funds for health promotion. As a synthesis, we propose an inter-sectoral governance perspective on investment for health.

Securing funds for health promotion: how much is needed?

While current resources for health promotion are perceived as insufficient [e.g. (Bennett, 2003; Wise and Nutbeam, 2007)], there seem to be few attempts at quantification on how many funds would be needed to reorient health services towards health promotion. Tangcharoensathien *et al.* (2005) recommend governments invest at least 15% of government expenditure into health promotion and prevention. This would represent a significant leap, given current health promotion expenditure according to OECD data. On the other hand, scholars questioning the effectiveness of health promotion argue that any extra resources spent in this area will not necessarily yield value for money (Lüngen *et al.*, 2009).

The quantity of resources needed for health promotion apparently remains a controversial issue. However, the lessons presented here also point to a meta-context of societal values such as solidarity, sustainability and stewardship. Recognized as highly relevant to financing health systems (WHO, 2000, 2005), these values may therefore be worth considering for health promotion financing.

Solidarity: who should pay for health promotion?

Solidarity as 'society's sense of collective responsibility' (WHO, 2005, p. 13) suggests that investment in health may also legitimize the involvement of actors beyond the health sector in financing this investment. However, complex causal pathways and a long time lag in health outcomes mean that those required to pay may

not be the direct, nor the only, beneficiaries of their investment (Bayarsaikhan and Muir, 2007). In Germany, even the proposed pooling of funds from four different branches of social security was deemed unfair, given the potential for free-riding by government, private insurance and unemployment services (Hajen, 2006).

The lessons from health promotion foundations suggest a more holistic perspective on solidarity that reconciles inter-sectoral funding sources and inter-sectoral allocation arrangements. Funds may be levied by the health insurance sector, but ultimately the entire resident population can pay for and benefit from health promotion action. This applies to Switzerland, where health insurance is mandatory for all residents. Similarly, in Austria, the amount of sales-tax revenue earmarked for the foundation is channelled through the industrial sector. Yet, the fact that this revenue is normally distributed among all levels and sectors of government (Hofmarcher and Rack, 2006) also renders health promotion financing a shared societal goal.

While the Austrian Industry Association criticized that health insurers, as alleged main beneficiaries of improved population health, were not involved in the collection side (ÖGV, 1998), insurers may still contribute as co-financing agents on the allocation side. Interestingly, co-financing can serve as a channel for inter-sectoral solidarity, but full financing, for example to small- and medium-sized Austrian companies due to the economic recession, can also strengthen solidarity in terms of the presumed ability to pay. Such acknowledgement of the needs of other sectors, in turn, represents a key to effective action on the social determinants of health (Kickbusch, 2010).

Sustainability and stewardship: a trade-off?

In securing funds for health promotion, policy-makers may face a trade-off between strengthening sustainability and stewardship, as two contrasting financing models illustrate. Government agencies, on the one hand, represent the traditional approach to achieving stewardship, but they are also the most vulnerable to annual budget revisions and spending cuts (Tangcharoensathien *et al.*, 2009). Classic private foundations, in contrast, tend to use a secured capital stock to finance specific purposes (Brand and Brand, 2000). Whereas this may strengthen

financial sustainability, opportunities for public sector stewardship are likely to be limited.

Health promotion foundations could alleviate potential sustainability-stewardship trade-offs. From the viewpoint of sustainability, health promotion foundations are entrusted with legislatively secured resources. Yet, in terms of stewardship, country experience indicates that legislative ring-fencing still enables upward or downward adjustment of funds. While this observation seems to contradict long-term planning for health promotion, a certain flexibility in the moving of funds between government activities might also enable more effective responses to societal needs (Lin *et al.*, 2008).

The statutory character of health promotion foundations, which allows relative freedom from political interference, may nevertheless threaten stewardship. Relative independence in daily operations and strategic planning can create coordination problems between foundations and Health Ministries (Mouy and Barr, 2006). Achieving joint stewardship with governments may be a major challenge for health promotion foundations, but arguably also one of their core potentials. Their ability to operate beyond rather narrow remits of single Ministries also facilitates inter-sectoral collaboration (Carroll, 2004). Thereby, health promotion foundations can, based on overall accountability to government, provide added value for public benefit across sectoral lines.

A synthesis: governing investment in health promotion through inter-sectoral action

An inter-sectoral perspective based on governance tools may help to frame the quest of securing funds for health promotion (St. Pierre, 2009). This entails thoughtful integration of micro-level analysis of single instruments, such as health promotion foundations, inter-departmental committees or community consultations, into macro-level policy frameworks such as *Health in All Policies* and *Investment for Health*, which emphasize the linkages between health, wealth and inter-sectoral collaboration (Wismar *et al.*, 2006; Ziglio *et al.*, 2000b).

As the Framework Convention on Tobacco Control is rolled out, more countries may be looking at health promotion foundations as an approach to dedicate 'sin taxes' levied on tobacco to health promotion action including, but going beyond, tobacco control. Various

countries especially in the Asian-Pacific region are at different stages of adapting the model to their contexts (VicHealth, 2005). Building on the experience of VicHealth, Thailand, for example, has dedicated 2% of the tobacco and alcohol excise tax revenue to a national health promotion foundation, ThaiHealth, to foster institutional development and programme delivery for health promotion (Buasai *et al.*, 2007). This serves as a role model to other low- and middle-income countries (WHO, 2010). Thailand has also mentored the development of new health promotion foundations, for example in Mongolia (Lin and Fawkes, 2006). The transferability of the foundation model to different national contexts illustrates the potential for cross-country learning. However, the experiences from Germany and Hungary also reveal how and why political, legal and economic contexts might impede the establishment of a health promotion foundation.

Even if policy entrepreneurs succeed in adapting the foundation model to a particular national context, single financing instruments are unlikely to change root causes of health inequalities. They will arguably remain limited in the context of potentially health-damaging supranational policies such as the Common Agricultural Policy of the European Union, and insufficient investment for health at national level, including public health education (Expert 4, 11 March 2010). To make a difference based on the limited resources they have, health promotion foundations arguably need two essential aspects for effective inter-sectoral action: they require embeddedness into a wider health promotion infrastructure (Ziglio *et al.*, 2000a), and they need to be enabled to act as change agents in collaborative action based on partnerships (Mouy and Barr, 2006).

IMPLICATIONS FOR POLICY AND RESEARCH

We suggest policy-makers and scholars should appreciate the inspiring alternatives for securing funds for health promotion that health promotion foundations offer. This includes legislation as a means to promote financial sustainability and complementarity, a range of potential funding sources beyond governmental health budgets and opportunities for inter-sectoral action.

In principle, the concept of health promotion foundations seems adaptable to various countries. However, health promotion foundations are not a magic bullet. Failed attempts to institute a health promotion foundation in some countries indicate the attractiveness, but also the limited transferability of this financing instrument in relation to political, legal and economic contexts. The Adelaide Statement on Health in All Policies (WHO/SA, 2010) emphasizes the need for collaborative and inter-sectoral governance in order to tackle the social determinants of health and health inequalities such as education, environment, housing and employment. To prevent duplication and fragmentation, health promotion foundations therefore require needs based integration into existing health promotion infrastructures and coordination with other governance tools. The Adelaide Statement explicitly calls for jointly reviewing innovative mechanisms and instruments to achieve a unified health promotion strategy. Thus, a useful next step for the future policy and research agenda might be to map and compare the added value of various governance tools, which may then contribute to implementing *Health in All Policies* within national contexts worldwide.

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